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ABSTRACT

The research described in this paper concerns nurses' alleged use of an indirect communication style, "The Doctor-Nurse Game," to influence physicians to change an order believed to be inappropriate for the patient. The paper is organized to (1) point out the parallels of the inappropriate order situation with a larger class of problematic, interpersonally sensitive situations; (2) examine the positive and negative functions of indirectness in those situations; and (3) develop a pedagogy for nurses' approaches to the inappropriate order situation that is consistent with a contemporary view of communication competence. The paper argues that the inappropriate-order situation resembles a "bind," where paradoxical demands and face-threat risks make initial indirectness a reasonable response. (Author/HOD)

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NURSES' INITIALLY INDIRECT INFLUENCE ATTEMPTS WITH PHYSICIANS: MAD, BAD, OR NEITHER?

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ABSTRACT

This research concerns nurses' alleged use of an indirect communication style, "The Doctor-Nurse Game," to influence physicians to change an order believed to be inappropriate for the patient. The purposes of the research are to 1) point out the parallels of the inappropriate-order situation with a larger class of problematic, interpersonally sensitive situations, 2) to examine the positive and negative functions of indirectness in the preceding situations, and 3) to develop a pedagogy for nurses' approach to the inappropriate-order situation which is cnsistent with a contemporary view of communication competence.

The paper argues that the inappropriate-order situation resembles a "bind," where paradoxical demands and face-threat risks make initial indirectness a reasonable response. The conclusion is further supported by data gathered from nurses' responses to a questionnaire which concerned varied risks in three phases of the inappropriate-order situation. Although nurses preferred a relatively indirect initial style (which they viewed as opening lines of communication and giving opportunities for joint problem-solving), it was often followed by more direct approaches. The recommended pedagogy is a contingent, strategic approach which involves the teaching of various styles of communication to nurses.

When a nurse believes a physician's order is not in the best interests of the patient (what will be termed here an "inappropriate-order situation"), and she attempts to secure a change to another order, she might say something like this to the physician: "Dr., I'm not sure I understand this order. Would you clarify it for me?" By not mentioning the desired action and by requesting information due to a lack of understanding, the comment in this particular context might be considered indirect--evasive, nonexplicit, avoidant, hinting. The nurse may be criticized by some as exhibiting "mad" or "bad" qualities: the nurse is playing the transactionally neurotic "Doctor-Nurse Game" (Stein, 1967) or she is exhibiting "feminine gamesmanship" (Bullough, 1975, p.231) which can only maintain her powerless position in relation to the physician (Johnson, 1967, p.316).

The prevailing ideology of the last generation has promoted directness, openness, and "up front" behavior as antidotes to ineffective communication. Only recently has this been seriously questioned. A prescription for open, direct communication style has been noted by some as an unwarranted ideology in the field of communication (Parks, 1982; Bochner, 1982). Pascale & Athos (1984, p.159) go beyond that assertion and state that explicitness is an assumption of our American culture. Furthermore, a growing body of research indicates that indirectness has pragmatically positive functions in problematic, interpersonally sensitive situations (Ervin-Tripp, 1976; Labov & Fanshel, 1977; Brown & Levinson, 1978; Pomerantz, 1980; Pascale &

Athos, 1981; Rawlins, 1983; Eisenberg, 1984). Judging a style, in and of itself, as "mad" or "bad", then, may not be useful or appropriate. The implications are that one style may not be best for all situations, a view consistent with contemporary views of communication competence (Spitzberg & Cupach, 1984).

The purposes of this paper are to 1) point out the parallels of the inappropriate-order situation with a larger class of problematic, interpersonally sensitive situations; 2) to examine the functions of indirectness in the preceding situations; and 3) to develop a pedagogy for nurses' communicative approaches to the inappropriate-order situation which is consistent with a contemporary view of communication competence.

NURSE IN A BIND

The situation in which a nurse believes a changed order would best serve the patient and in which she is ethically, if not legally, required to secure a change, is particularly problematic, resembling Bavelas' notion of "bind":

> caught between two or more incompatible aspects of the situation, and furthermore, still required to communicate. (1983, p. 132)

A further elaboration of the concept "bind" adapts Lewin's conflict theory (1938) and points out the implications for the required communication:

> an avoidance-avoidance conflict, in which two ununappealing choices repel the individual, who will leave the field if possible--in this case, communicationally, by evasive or indirect communication. (Bavelas, 1983, pp. 138-139)

Leaving the field, then, is accomplished by "a message that says something without really saying it--one that is evasive, indirect, or effectively ambiguous in some other way" (Bavelas &

Smith, 1982, p. 214). Bavelas' research (1983) in which subjects selected an initial comment in a bind or nonbind situation supported her theory about the association between binds and disqualification, a particular type of indirectness.

Two analysts of nurse-physician communication, Rushing (1962-63) and Stein (1967), reveal the particular bind-like characteristics of the inappropriate-order situation and the new-order situation. Rushing describes the nurse's position in the inappropriate-order situation as "a conflict between two normative principles of the nurse: the patient's welfare and the doctor's authority" (p. 371). In Rushing's study undesirable and extreme responses to the situation were complying with the order (consistent with the second principle), directly recommending a change, and refusing the order (the latter two responses consistent with the first principle). The majority of nurses in his study reported they would use influence attempts to deal with the situation--most frequently trying to influence the physician by either reporting patient observations which would contraindicate the physician's order or by asking questions which reflected a lack of the nurse's understanding of the order. Though influence attempts may not seem to be in conformity with the physician's authority, nurses acknowledge that authority and competence by <u>not directly</u> telling the physician what to do. Simultaneously, the patient's best interests are served. The risks of damaging interpersonal relations with the physician and thereby future effective teamwork and patient care are reduced.

Stein, in an oft-quoted and reprinted article, "The Doctor-

Nurse Game"(1967), states that nurses receive paradoxical messages when they want to recommend a new order: that the physician is omniscient and making open and direct recommendations to him is insulting, and that the nurse is an invaluable source of information and is obliged to contribute that information. But the paradox can be escaped: by making recommendations without appearing to do so and waiting for the physician to sense and state the desired order, the nurse fulfills the requirement to communicate and take action for better patient care while acknowledging the physician's position. Though Stein acknowledges the unusual efficiency of the indirect style of communication (for physicians as well, as they try to indirectly elicit a recommendation from nurses) and the various personal and interpersonal rewards in the game, he soundly criticizes the indirect style as "stifling and anti-intellectual" and as a reinforcement of the physician's rigid position of omnipotence and of the sex-role stereotypes of feminine passivity and male dominance (p. 703).

In the same vein as Stein, Johnson (1976, 1978) in her analysis of and research on indirect power strategies and women, condemns the "Doctor-Nurse Game" as a form of indirect informational power. Equating indirectness with manipulation, Johnson (1978) points out that if indirect but effective strategies are not detected as power strategies, the influencer will not get credit for her actions and cannot build a base for future influence. Thus, in the "Doctor-Nurse Game", the physician gets the glory, but the nurse nothing. The negative view of indirectness is also echoed in a multidimensional study

of power strategies in which experts rated indirect strategies as negative and passive (Falbo & Peplau, 1980) and machiavellian (Falbo, 1977).

On similar grounds, Bullough (1975) denounces nurses' use of indirectness with physicians as "feminine gamesmanship," based more on past tradition than present reality (p. 231). In an unpublished study of the inappropriate-order situation and the nurse portion of the "Doctor-Nurse Game" (reported partially within another article), Bullough found that nurses preferred indirect opening lines to a physician who was described as being "adamant" and "insistent" about orders (p. 231). She also found that physicians overall, but younger ones in particular, preferred a direct approach from nurses. But Bullough's results on nurse and physician preferences are incompletely reported, thus hampering evaluation of the study. Furthermore, this study can be criticized for its negatively slanted indirect choices, its depiction of the physician, for its conclusions about nurses' and physicians' preferred styles across the situation based on an opening line, and it reasoning that the nurses' fears are unrealistic, objections dealt with more completely in Cunningham (1983).

In both Stein's and Rushing's analyses of the situations, the bind-like qualities emerged: the requirement to communicate is suggested, the avoidance-avoidance (paradoxical) nature of the situation is specified, and the solution of an indirect communication style, at least initially, is noted. But while Stein (1967), along with Bullough (1975) views the indirectness

as mad and bad, Rushing views it an neither--just a response which simultaneously maximizes the multiple goals of the nurse in the situation. As Bavelas states in regards to disqualification, it is "a reasonable response to an impossible situation," neither erroneous nor pathological (1983, p. 136).

NURSE OUT-OF-CHARACTER IN A FACE-THREATENING SITUATION

Another way to view the nurse-physician inappropriate-order situation is as a face-threatening one involving out-of-character or out-of-role behaviors for the nurse. Goffman defines "face" as"the positive social value a person effectively claims for himself by the line others assume he has taken during a particular contact" (1967, p. 5). "Face-work" refers to actions which prevent the occurrence of such face-threatening or risky events or embarrassment, humiliation, conflict, and offensiveness (1967, pp. 12-13). Some avoidance face-work acts include hinting, which is unofficial and can be denied: the person who hints is not held accountable for the implied action. Hints can serve as a warning of possible face loss without creating an incident, thus reducing interaction risk. According to Goffman, individuals in interaction are required to attend to their own and others' "face." Face-work functions to maintain "face" for both nurse and physician. Thus, apart from task goals, impression management/social goals are inherent in any situation.

Incorporating Goffman's notion of "face," Brown and Levinson (1978) and Ervin-Tripp (1976) note elements of risk in face-threatening situations and the role of indirect, nonexplicit tactics in obtaining desired actions while simultaneously satisfying face wants. Some of the factors they identify are: 1)

speaker needs and desires and social variables such as social distance, power, and degree of imposition (Brown & Levinson, 1978); and 2) rank/status, familiarity, likelihood of compliance, task difficulty, and duty expectation (Ervin-Tripp, 1976). Both researchers agree that some degree of indirectness can satisfy the dual wants to go on- and off-record simultaneously. Furthermore, Ervin-Tripp notes that, unlike direct forms, nonexplicit forms of request entail fewer obligations and more options for the hearer. Indirectness functions to maintain "conversational continuity" and obscure "interpersonal failure" (1976, p. 50). In some cases when indirectness has been routinized, it also enhances group solidarity. However, Ervin-Tripp also warns that indirectness may incur a heavy cost: misunderstanding. This cost, though, seems to apply to situations in which indirect approaches are used in succession vs. used initially only, a point to be considered at the end of this section.

Goffman's (1959, p. 190-205) analysis of how interactants realign actions when their discourse is technically "out-of-character" is particularly applicable to the inappropriate-order situation. Realigning actions allows a temporary deviation from the usual relationship through "unofficial communication" or "putting out feelers"--hinted ambiguous demands and "gradual guarded disclosure" which test whether the usual social distance and formality can be changed for the moment (1959, p. 194). In particular, Goffman observes this behavior in subordinate-to-superior interaction on topics "officially outside the competence

and jurisdiction of the subordinate but which actually depend on him" (1959, p.194). Thus hinted communication is a socially safe way (avoiding face-threat) to make and refuse requests which, if done more openly, might require altering the relationship.

Considering that nurses are not officially supposed to know more than physicians (though Stein, 1967, says that physicians depend on their information) and that they are not supposed to make diagnoses or prescribe orders, nurses' use of hinted or deniable communication when they wish to secure an order change can be viewed as a realigning action. Likewise, when physicians indirectly elicit order recommendations from nurses, as in the physician side of the "Doctor-Nurse Game" (1967), they too are realigning actions. The effect is paradoxical: the traditional role relationship is maintained while being altered for the moment. As in Rushing (1962-63), a social constraint is adhered to while being circumvented.

Redland's study (1983) is particularly relevant to Goffman's concepts of realignment of actions and face-threatening situations. In a naturalistic setting, she studied 52 nurses' communication styles when they interacted with and made patient care interventions (PCI) with physicians. She coded observed behaviors into categories corresponding to Thomas' Conflict Management Styles (1976): avoidance, competition, accomodation, collaboration, and compromise. Her category of accomodation includes some behaviors which are consistent with the idea of indirectness: "states position through questions" and "uses veiled recommendations" while her collaborative category includes more relatively direct communication: "states position, states

differences, provides information/rationale" (p.17). Avoidance, in this coding system, refers mainly to not utilizing opportunities to interact with the physician.

Redland found that when the most frequent types of interventions were made, those concerning medical orders (the addition, deletion, or alteration of orders) and diagnostic tests, an accomodative style was used most frequently by B.S.N nurses, who tended overall to use more collaboration than diploma graduate nurses. When P.C.I. were not suggested, though, a greater use of collaboration for both types of nurses was evident. Redland's explanation is that medication and diagnostic decisions are "commonly accepted as the physician's prerogative" (p. 13). She further explains that "An air of equality is easier to achieve when the nurses do not place themselves in the position of being overruled by physicians" (p. 14).

In Goffman's terms, the intervention about orders is "out-of-character," thus an accomodative style, encompassing indirectness, is used. The degree of imposition on the physician by making such interventions, the differences in power/rank between physicians and nurses and the likelihood of physician compliance -- variables mentioned before as affecting the face risks -- may have contributed to Redland's findings. A study by Cunningham and Wilcox (1984), to be discussed later, examined factors related to those mentioned above.

The above sections point out that the inappropriate-order situation is not unique, but analogous to other bind-like, face-threatening situations. From those perspectives, indirectness is

neither mad nor bad, but may be a logical solution to a paradoxical situation in which the nurse has not just one goal, but several. But the nurse studies viewed this far do not distinguish between initial directness and continued or later directness and do not consider degrees of directness/indirectness. Stein (1967) assumes the indirect style predominates the encounter, though in his prototypical example of the "Doctor-Nurse Game," the nurse becomes increasingly specific about the desired order--at the end, she mentions the order, but does not explicitly recommend it. Mentioning the order, it seems, is far more direct than reporting the patient's condition. Ervin-Tripp (1976) notes that explicit forms often refer to the desired new action. Rushing (1962-63) allowed his subjects multiple responses, so it is not clear if sequence was considered by nurses. He too did not distinguish between the indirectness involved in asking for a clarification and that involved in stating patient observations which contraindicate an order. Redland (1983) considered overall styles for an encounter by summing behaviors noted in each category, resulting in a loss of information about sequence of behaviors. Bullough (1975) seemed to assume that an opening line choice indicated a predominant style of indirectness.

SEQUENCE OF INDIRECTNESS/DIRECTNESS

To begin to explore the sequence of nurses' communication behaviors in the bind-like, face-threatening, inappropriate-order situation, Cunningham (1983) examined three possible phases of the situation. The study (parts of which are reported in Cunningham and Wilcox, 1984) examined the effects of three risk

factors, based on the face-risk literature as well as nurse communication literature: expected patient condition if the order is carried out (serious harm vs. slight discomfort), expected physician response (negative vs. positive), and physician status (experienced attending physician vs. 1st year resident). These factors were expected to loosen or tighten the bind of the inappropriate-order situation, resulting in variations in nurse communication choices. The three phases involved 1) initial actions taken to handle the situation, 2) initial comments to the physician to secure an order change and 3) further behavior if the initial comments were unsuccessful in securing an order change. The questionnaire used in the study described one of eight hypothetical inappropriate-order situations in which risk factors were varied. Subjects were asked to respond to the three possible phases of the situation. The Cunningham (1983) and Cunningham & Wilcox (1984) studies are distinguished from prior research insofar as not only are initial moves sought but follow-up or later moves are derived -- the assumption being that bind-coping may involve a sequence or pattern of moves, an interaction in which nurses may be able to become more direct and physicians more receptive. The main concern of this present paper is with phases 2 and 3.

For the second phase, initial comment choices were constructed, based on nurse-consultants' input and previous nursing research, and were varied from direct to indirect, based on Stein (1967), Bavelas (1983), Bavelas & Smith (1982), Ervin-Tripp (1976), Brown & Levinson (1978) and others (see Cunningham,

1983). Acknowledging that indirectness may not be strictly dependent on characteristics of the isolated message, but also dependent on the situation, the speaker's intention, and the listener's interpretation, Cunningham (1983) performed a study prior to the main study. The purpose of this study was to find out how nurses would rank initial comments to a physician on a direct-indirect and explicit-inexplicit continuum in the context of a general inappropriate-order situation in which the nurse's intention to secure an order change was specified. Nurses' ranks of the messages corresponded with the researcher's ranks. Nurses in the main study both rated their probability of saying "something like" the initial comment choices and selected a top choice. Nurses were then asked to indicate whether they would pursue the matter further ("Yes" or "No") and to specify what that further action(s) would be.

The results of the first phase indicated that nurses prefer confronting the physician, either immediately or after consulting with another person for advice. The decision between choosing the latter or former alternatives depended on the three factors.

The results of the second phase indicated that nurses preferred, overall, the middle choices of the following:

DIR 1: "Doctor, I'm not sure I understand this order. Would you clarify it for me?"
DIR 2: "Doctor, I'm concerned about possible negative effects with this order. Could you explain the order to me?"
DIR 3: "Doctor, I'm concerned about X and Y effects with this order. Would some other order eliminate these effects?"
DIR 4: "Doctor, I recommend a change to order Z. In my experience it has eliminated the X and Y effects."

However, the expected patient condition made a difference in

nurse initial comment preferences. DIR 3 was significantly associated with the slight discomfort condition and DIR 1 and 2 were significantly associated with the serious harm condition. Thus, more directness was preferred in the low patient risk condition, and more indirectness was preferred in the high patient risk condition. The middle choices make use of nurses' information and seem oriented to the problem and/or a solution vs. DIR 1. DIR 1 depends on the physician to ferret out the problem and arrive at a solution. DIR 4 presents the problem and a solution independent of the physician's input. Thus, nurses seemed less concerned with appearing knowledgeable or they relied less on solely their own judgments (which could be faulty) when the patient was in serious danger. Utilizing the bind metaphor, the serious harm condition seemed to tighten the bind initially, eliciting more indirectness than would be expected.

In the third phase, the vast majority of nurses (>80%) indicated they would pursue the matter further. In the third phase, the vast majority of nurses overall (> 80%) indicated they would pursue the matter further. The small minority who chose not to tended to be in the slight patient discomfort condition and, to a lesser degree, in the negative physician condition and high physician status conditions. But even in those conditions the ratio of "pursuing the matter further" to "not pursuing the matter further" was more than 2 to 1. Opening lines, then, are not seen as final solutions to the problem.

The actions which the nurses specified they would use to pursue the matter further seem to be characterized as direct and forceful. Table One reports those results, which are based on a

content-analysis of nurses' written responses.

TABLE 1

Pursuing the Matter Further: Summary of Content Analysis

	Sample 1 N = 108 ("yes" respondees)	Sample 2 N = 125 ("yes" respondees)
1. Further Interaction with the Physician	n = 50 (46.30%)	n = 52 (41.60%)
a. Giving more specific information on reasons for a change	17	23
b. Mentioning another order	16	29
c. Refusing to carry out the order	9	8
d. Asking for a clarification or explanation of the order	9	10
e. Restating points made already	2	0
f. Other	5	3
Subcategory Total	58[a]	73[b]
2. Conferring with and Involving Others	n = 28 (25.92%)	n = 34 (27.20%)
a. Nurse supervisor	13	22
b. Another or a higher-ranked physician	14	16
c. Pharmacist	1	2
d. Peers	1	0
e. Chain of command	0	1
f. Patient	1	0
Subcategory Totals	30[c]	41[d]
3. Further Interaction with the Physician Followed by Con-		

ferring with and Involving Others	n = 13 (12.04%)	n = 25 (20.00%)
a. Giving more specific information on reasons for a change	2	5
b. Mentioning another order	2	2
c. Refusing to carry out the order	7	14
d. Asking for a clarification or explanation of the order	1	6
e. Restating points already made	2	2
f. Other	2	6
Subcategory Totals	16[e]	35[f]
g. Involving the nurse supervisor	4	15
h. Involving another or a higher-ranked physician	7	8
i. Involving a pharmacist	0	1
j. Involving peers	1	0
k. Involving all persons in the chain of command	1	2
Subcategory Totals	13	26[g]
4. Miscellaneous	n = 4 (3.70%)	n = 3 (2.4%)
a. Not carry out the order	2	0
b. Conferring with other persons, followed by further interaction with the physician	2	3
Subcategory Totals	4	3
5. Unusable Items	n = 13 (12.04%)	n = 11 (8.80%)
a. Answered "yes" but		

gave no written answer	10	9
b. Unclear responses	3	2
Subcategory Totals	13	11

a Multiple responses in the subcategories numbered 8.

b Multiple responses in the subcategories numbered 21.

c Multiple responses in the subcategories numbered 2.

d Multiple responses in the subcategories numbered 7.

e Multiple responses in the subcategories numbered 3.

f Multiple responses in the subcategories numbered 10.

g Multiple responses in the subcategories numbered 1.

Both samples indicate that approximately 60% would choose further interaction with the physician. A direct refusal of the order, the sharing of relevant, specific information about reasons for a change, and mentioning another order were the most frequent sub-categories under categories #1 and #3 when summed across samples -- certainly reflecting a movement toward more directness and an effort to handle the matter themselves before involving others. Approximately 25% would only involve others who may have more "clout" in the situation, which may be considered as more forceful since it is a two-against-one move.

The preceding results have implications for the bind of the inappropriate-order situation. While certain conditions make the bind looser or tighter initially, the bind seems to become looser as the episode proceeds -- nurses may feel freer and less concerned about face, resulting in order refusals and suggestions about specific orders. The point to be made here, is that an

initially indirect influence attempt does not preclude later more direct or forceful behaviors. Furthermore, an opening comment may not characterize the whole encounter.

The above contentions are consistent with Pomerantz (1980) and Beach and Dunning (1982). Pomerantz analyzes "fishing," an indirect tactic in face-threatening situations to elicit information or a desired action from another person. "Fishing" gives the other person an opportunity to volunteer information or make offers without being asked directly. As in previously mentioned research, Pomerantz notes that indirectness reflects a social constraint which is both adhered to and violated simultaneously. Pomerantz suggests that successive "fishing" devices may be different from earlier ones, with later requests being more direct, reflecting a relaxation of the social rule. In an article on pre-indexing devices, Beach and Dunning (1982) also note that indirectness is likely to precede and "test the water" for more face-threatening acts (p. 175). Thus, while the task goal may be secondary to social goals initially, the reverse may be true for successive moves. Salience of task and social goals at various points in the sequence should be considered in future studies of nurse-physician communication. Eisenberg's discussion of "strategic ambiguity", akin to indirectness, is relevant: "While strategic ambiguity may be thought of as a way of coping with multiple goals, the priorities individuals assign to these goals may be highly variable" (p. 233).

Nurses' rationales in the Cunningham (1983) study for their selection of particular opening lines to the physician reflect their multiple goals, a positive function of initial

indirectness, and a persistence in effecting a solution in the patient's best interest. Nurses reported a real concern for relational risk with the physician. They often supported their selection of comments with the mention of tact, diplomacy, courtesy, non-offensiveness, and the need to give the physician an "out." On the other hand, they were also concerned with their image, as in this subject's rationale:

> Responses #11 and #12 [DIR 1 & 2] are truly wimp responses, perpetuating the nurse-handmaiden image, decreasing the odds physicians will ever consider nurses as colleagues rather than servants.

But they also saw that some degree of initial indirectness had task value. Several respondents indicated that DIR 1, 2 and 3 had the ability to open lines of communication for further discussion and exploration of the issues, giving them and the physician the opportunity to learn something from each other. With a direct statement, the opportunity is diminished, as the solution is handed to the physician to be rejected or accepted. The following rationales from R.N.'s reflect the positive function of some indirectness, especially when the order may lead to serious patient harm:

> This statement opens up a line of communication without being too intimidating, which will turn a doctor off for further communication.
>
> (R.N. in serious harm condition, rationale for DIR 1 choice)

> We can't know all the circumstances. Either one of us could not know <u>the best</u> procedure and we could learn from each other and benefit the other.
>
> (R.N. in serious harm condition, rationale for DIR 1 choice)

> This statement is specific in that it states I'm aware of negative effects and yet broad

enough to allow an open discussion c the M.D. about the order. It may be the positive effects of the order override the negative.
(R.N. in serious harm condition, rationale for DIR 2 choice)

By opening a discussion in this way [DIR 2], I would be showing concern for the patient & the course of his care. I would also demonstrate my knowledge of the situation & the treatment, drugs, or whatever. I would be showing a willingness to listen to him & to learn from him--rather than challenge him or create hostility.
(R.N. in serious harm condition, rationale for DIR 2 choice)

It expresses your concern but also gives him the opportunity to make a suggestion, express his opinion, &/or accept discussion. It seems more appropriate than saying you're wrong, do this.
(R.N. in serious harm condition, rationale for DIR 3 choice)

With initial indirectness (often involving a smaller request than might be posed later), the nurse, in essence, gets a "foot-in-the- door" (see Dillard, Hunter & Burgoon, 1984 for a meta-analysis of this tactic), serving a collaborative, problem solving function.

Nurses in the Cunningham (1983) study also showed evidence of persistence. If all the "Doctor-Nurse Game" entails is indirectness throughout an episode, then real risk to the patient and the image of the nurse must be considered. Johnson (1978) points out that if indirect power strategies are not detected as such, the influencer will not get credit for the actions and cannot build a base for future influence. Furthermore, misunderstanding can result. But the "Game" can involve more than initially indirect comments, as one subject in the Cunningham study illustrates:

I am willing to play the game for the pts. sake--ask for advice, explanations, etc. try to suggest

alternatives and reach compromise before I refused to carry out the order.

In Falbo's (1977) study of ratings of power strategies "persistence" was associated with the "direct" end of the indirect-direct continuum, inversely related to machiavellianism.

In sum, the preceding sections suggest the usefulness of viewing the inappropriate situation not as a unique situation, but as one which has bind-like qualities and face-threatening elements in which task and social risks are considered. The view highlights the positive pragmatic functions of indirectness, especially initial indirectness, and suggests that some degree of initial indirectness does not preclude, but may even facilitate future directness. The resulting implications for pedagogy will be explored below.

PEDAGOGICAL IMPLICATIONS

The results of the Cunningham & Wilcox study (1984) indicate that nurses report they would adapt their communication to meet the needs of the patient and the physician in the particular situation, given the available choices. The need to be flexible is illustrated by one nurse's comment: "Again, I want to be fair with the Doctor, not come off like I'm being assertive for assertiveness sake!" Adaptation is an important part of allaying and preventing nurses "reality shock" (Kramer, 1974). The goal of Kramer's training programs for nurses was to have them express professional values in a new way: "the new graduate was not bound to either rigid bureaucratic or professional responses but was free to respond in a creative way to meet the unique situational demands" (Kramer, 1974, p. 114). Adapting

communication to meet the needs of the people and the situation is a basic characteristic of communication/relational competence (Weimann, 1977; Littlejohn & Jabusch, 1982; Fisher, 1982; Spitzberg, 1983; Spitzberg & Cupach, 1984), communication effectiveness (Knapp, 1978),and rhetorical sensitivity (Hart & Burks, 1972; Carlson, 1984). Fisher (1982) defines relational competence as:

> not simply showing empathy or attempting to "manage" the interaction, but adapting to the other person(s) and, more importantly, to the relational situation and the developmental stage of the relationship. Such adaptation may, in one case, involve a display of affiliation/support and, in another, a display of domineering or submitting behavior. No particular behavior can be said to be a display of communicative competence in all situations and all relationships (or even in the same relationship at different times).
> (Fisher, 1982, p.43)

The rhetorically sensitive person is described by Carlson (1984):

> Not only does this person recognize the multiplicity of ways of ways of expressing ideas, but also is willing to search through the various alternatives and select and enact the best alternative for the self, the other, and the situation. . . . A rhetorically sensitive person is constantly weighing the consequences of communicative choices. . .
> (p.17)

What is involved in nurses' communicating flexibly in the inappropriate-order situation? First, nurses need to be aware of relevant aspects of the situation, to know to what they are adapting. Some of the key factors have been identified. The first set of factors relates to medical concerns: 1) the potential patient consequences (Cunningham & Wilcox, 1984; Stanley, 1979); 2) urgency of the situation (Benjamin & Curtis,

1981); 3) the medical acceptability-nonacceptability of the order (Stanley, 1979; Benjamin & Curtis, 1981). The second set of factors relates to the physician: 1) the physician's competence (Stanley, 1979); 2) the type of relationship the nurse has with the physician ("Nursing Ethics", 1974; Stanley, 1979); 3) the physician's likely response (Cunningham & Wilcox, 1984); and 4) the physican's status or experience (Cunningham & Wilcox, 1984). Other factors concern the hospital organization: the hospital's procedures for dealing with the situation, the type of physician hierarchy, and the hospital's supportiveness to nurses disagreeing with physicians' orders (Stanley, 1979). An awareness that nurses' perceptions of the situation may not be reliable, that the situation may change as it progresses, and that some needed information may not be known is also necessary to handle the situation flexibly.

Secondly, nurses need knowledge of their possible goals and alternatives in the situation and the consequences of those alternatives. In line with the Cunningham & Wilcox study (1984), a knowledge of sequences of possible goals and alternatives is also helpful for nurses to better anticipate their most effective move and to guard against closing off discussion before all goals are accomplished. For example, a nurse may have multiple goals in a given inappropriate-order situation: task, self-presentation, and relationship goals (Clark & Delia, 1979). In some situations, certain goals may be best accomplished earlier in the interaction. Establishing rapport, a relationship function, may be advisable before proceeding with task goals: it can open lines of communication and serve to gather more

information about the physician before engaging in more face-threatening acts.

A further reason for considering sequence of goals and alternatives is that the task goal in the inappropriate-order situation may be tentatively held, have multiple dimensions, and may change during the episode. The nurse may want more information, want to influence the physician, and want to involve the patient in the decision, for example. Some of these task goals may not be clear until all the information about the situation is determined (if it can be) in the course of discussion. Few decisions about medical cases are open-and shut, not requiring the judgment and input of several persons. The goal to influence the physician seems to assume the nurse has all the answers. In some situations, the goal to influence the physician may be premature. Fritz, Russell, Wilcox & Shirk (1984) warn that when "one partner assumes the other person has no resources to offer or no knowledge to share, nonoptimum communication may result"(p. 29). While a request for more information seems an indirect way to influence the physician to change an order, it may also reflect an additional, more salient task goal of gathering more information before a commitment to influence the physician or take other action. It is possible that nurses in the Cunningham & Wilcox (1984) study had such a privately-held information-gathering goal, in addition to the specificied hypothetical goal to secure an order change from the physician. Tracy (1984) discusses the need to study the effect of multiple goals on subjects' discourse choices, as subjects may

bring more goals to the research situation than are established by the researcher.

To summarize the points above, teaching a contingent problem-solving process to nurses for making communication decisions in the inappropriate order situation is suggested. Such a process would involve: 1) considering relevant situational factors, some of which may change dramatically during the episode; 2) considering a range of goals, some of which may be more appropriately sought earlier than later in the episode; 3) considering a range of communication alternatives to accomplish the most salient goals at a given time; and 4) anticipating the consequences of the alternatives. Particular attention should be given to examining communication alternatives which force a premature closure of discussion before goals are accomplished. The Cunningham & Wilcox study (1984) indicates that initially indirect influence attempts are alternatives which can allow multiple goals to be sought simultaneously and can open lines of communication so a joint solution can be negotiated. Making a recommendation to the physician to change to a specific order may disallow such collaboration.

Third, the prescription to be adaptable or flexible implies the nurse needs proficiency in a wide-repertoire of communication behaviors. Not only is it helpful to teach nurses assertive or more direct styles and strategies (Clark, 1978; Herman, 1978), but also indirect communication skills and related skills of tact, diplomacy, politeness (Brown & Levinson, 1978), and "information control" (Eisenberg, 1984). The advantages of indirectness, particularly as an initial strategy, have been

discussed in this paper. Pascale & Athos (1981) note that

> Skilled executives develop the ability to vary their language along the spectrum from explicitness to indirection, depending on their reading of the situation. (p. 228)

The training of such skills could be accomplished through roleplay rehearsal in realistically-designed inappropriate-order situations in which physician, medical, and organizational factors are varied. In their book on communication competence, Spitzberg & Cupach (1984) present a useful model of social skill training by Ladd & Mize (1983) which involves 1) a cognitive component, 2) skill performance development (rehearsal, evaluation, refinement), and 3) the maintenance and generalization of the knowledge and skills by students.

Given the conscious, strategic approach outlined above, a further consideration needs discussion. Spitzberg & Cupach (1984) warn that self-awareness is similar to anxiety -- too much awareness can detract from communication competence. They point out the following:

> We must seek to indicate under what conditions it is more important to monitor closely and under what conditions spontaneity is in order. Teaching someone how to strike the proper balance between strategies orientation and spontaneity is extremely difficult -- akin to teaching creativity. (p. 183)

The inappropriate-order situation seems to be one which demands a more strategic orientation, particularly initially as the bind seems to be tighter and situational factors are more uncertain or unknown. More importantly, a patient's welfare is at stake. But situations in which the urgency is low and patient risks and interpersonal consequences are minimal, may not need high self-

monitoring of communication moves. Recommended is that the contingent strategic approach outlined above should be tested and refined.

SUMMARY

Our pedagogial guidelines derive from an assumption that an indirect nurse response to an inappropriate-order situation is both reasonable and workable --i.e., it may function as a key to unlocking a sequence of behaviors which loosen and eventually unravel the bind. If this is the case, communicative competency for nurses will clearly be defined as we have indicated, as flexible and adaptable.

This process, however, involves another key individual -- the physician who issues what the nurse perceives as an inappropriate order. Both nurse and physician will orchestrate the sequence of behaviors just referred to. As such, communicative competency will have to be conceptualized as not simply the ability to make a statement (direct or indirect) at any point in the sequence. Instead, it will need conceptualization as an interactional phenomenon and studied in such a way as "to be able to see the extent to which referents are tied to situations and be able to evaluate the mutual influence of speakers' ongoing choices of subsequent use of referents in conversation" (Diez, 1984, p.75). Diez further states

> Viewing conversation or interaction as a continually negotiated process leads to the examination of communicative competence as a processing or producing capability best discovered in natural talk.
> (p.75)

Our feeling is that a next appropriate research inquiry is the analysis of samples of natural talk and from the frame of reference of the coordinated management of meaning approach developed by Pearce, et. al. (1981). If the appropriate order situation can be defined as episodic, it can be analyzed for its rules structure with both explanatory and predictive value.

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